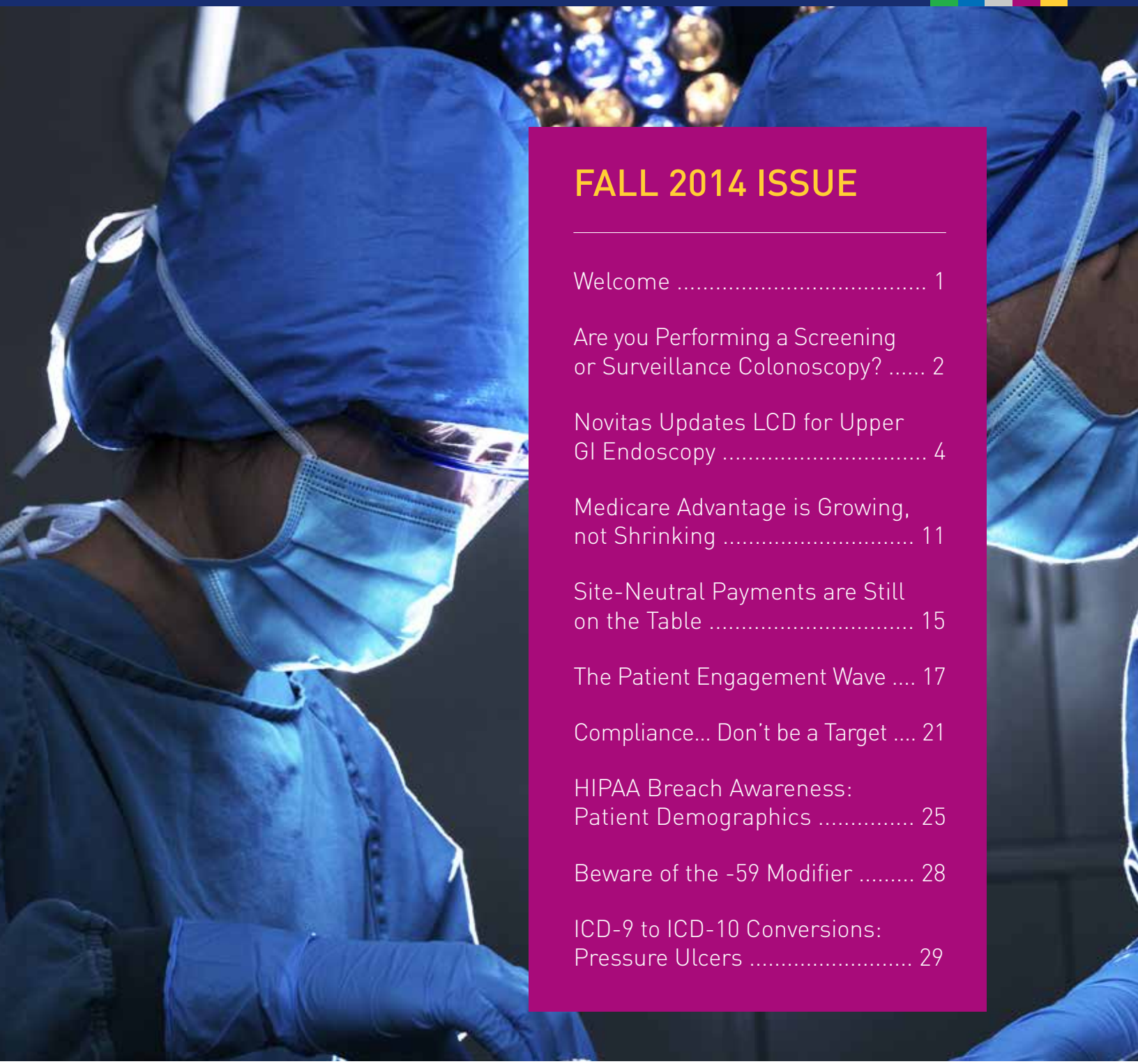
THE LEADING EDGE



FALL 2014 ISSUE

THE LEADING EDGE

Welcome!

Welcome to the Fall edition of the Leading Edge. In this issue we start by describing the difference between a "screening" vs. a "surveillance" colonoscopy.

We also describe recent Novitas LCD updates for upper GI endoscopy which require more specific physician documentation.

Do you know Medicare Advantage? I was very surprised to learn that nearly a third of Medicare enrollees are not in traditional Medicare! Instead, they choose what looks like a commercial plan, except that is underwritten by Medicare instead of the patient or an employer. Despite serious attempts to limit the growth of Medicare Advantage plans, they continue to expand.

Next we look at "site neutral payments." Or, we should say, attempts to achieve site neutral payments—from several different directions. While nothing is imminent in this area, the tea leaves suggest that the pressures to have the same rate, regardless of site of service, will continue to build.

Following that, we highlight "patient engagement." Engaging patients is at the foundation of nearly every current trend in healthcare and one of the most important components of health care reform. Studies now show that engagement results in improved outcomes and lower costs. We describe the benefits and the hurdles that remain.

I hope that you recently saw our announcement of new Compliance Support services. If not, you need to read "Compliance Requirements...Don't be a Target!"

While on compliance, we have a surprising piece on patient demographics and how easy it is to run afoul of HIPAA requirements.

Finally, we have important reminders about Medicare revalidation and the 59 Modifier. Plus our ongoing series of ICD-9 to ICD-10 conversions.

One final note: we've improved the "Print" functionality (works nicely to print or create a PDF of a single article) and added a "Download Current Issue" button. The latter provides a PDF of this entire issue if you prefer to read or share it in that form.

As always, we appreciate your feedback and suggestions. Please call or email me with comments and future topics: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

Are you Performing a Screening or Surveillance Colonoscopy?

Our coders are finding many times where they cannot determine from the documentation in the medical record whether the physician is performing a "screening" or "surveillance" colonoscopy. With the rise in requests for screening colonoscopies (since it is now a "covered benefit" under the Affordable Care Act-ACA), physicians may not understand that most colonoscopies are actually not "screening" but instead are the result of "surveillance" regimens.

It is important for our coders to know this information in order to code appropriately. It is also important that practices who perform their own coding understand the difference in reporting a "screening" vs. a "surveillance" colonoscopy.

As part of the preventive services section of the ACA, a true screening colonoscopy will be covered in full by insurance carriers, with no patient balance or deductible. But that is no reason to code a screening colonoscopy it if is indeed a surveillance.

A ***screening*** colonoscopy as defined by the U.S. Preventive Services Task Force (USPSTF) is a colonoscopy performed once every 10 years for asymptomatic patients aged 50-75 with no history of colon cancer, polys and/or gastrointestinal disease.

Whether a polyp or cancer is ultimately found does not change the screening intent of the procedure. Screening involves one or more tests performed to identify whether a person with no symptoms has a disease or condition that may lead to colon or rectal cancer. The goal is to identify the potential for disease or the condition early when it is easier to prevent or care for.

A ***surveillance*** colonoscopy can be performed at varying ages and intervals based on the patient's personal history of colon cancer, polyps, and /or gastrointestinal disease. Per the USPSTF, "When the screening test results in the diagnosis of clinically significant colorectal adenomas or cancer, the patient will be followed by a surveillance regimen and recommendations for screening are no longer applicable."

Although non-Medicare insurance carriers normally do not accept G codes in place of CPT codes, many carriers do accept the G codes for colonoscopy billing.

There are 3 types of colonoscopies that must be distinguished in the medical record for correct billing.

Preventive colonoscopy screening

CPT®45378 *– Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)*

G0121 *– Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk*

- Patient is 50 years of age or older
- Patient does not have any gastrointestinal sign, symptom(s), and/or relevant diagnosis
- Patient does not have any personal history of colon cancer, polyps, and/or gastrointestinal disease
- Patient may have a family history of gastrointestinal sign, symptom(s), and/or relevant diagnosis

Exception: Medicare patients with a family history (first degree relative with colorectal and/or adenomatous cancer) may qualify as "high risk." Colonoscopy for these patients would not be a "surveillance," but a screening, reported with HCPCS Level II code G0105 Colorectal cancer screening; colonoscopy on individual at high risk.

Acceptable diagnoses:
- V76.51 – Special Screening for malignant neoplasms of the colon
- V18.51 – Family history of colonic polyps
- V18.59 – Family history of other digestive disorders

Surveillance Colonoscopy

45378 – Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)

G0105 – Colorectal cancer screening; colonoscopy on individual at high risk
- Patient does not have any gastrointestinal sign, symptom(s) and/or relevant diagnosis
- Patient has a history of colon cancer, polyps, and/or gastrointestinal disease

Acceptable diagnoses:
- V16.0 – Personal history of malignant neoplasm of the gastrointestinal tract

Diagnostic/Therapeutic Colonoscopy

A ***therapeutic*** colonoscopy is performed to treat a known problem such as cancer, polyps, or bleeding. The common uses of therapeutic colonoscopies are hemostasis, resection and ablation of benign and malignant disease, decompression and recanalization of obstructed or dilated bowel, as well as foreign body extraction.

A ***diagnostic*** colonoscopy is a test performed as a result of an abnormal finding, sign or symptom (such as abdominal pain, bleeding diarrhea, etc.)

45378 – Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
- Patient has a gastrointestinal sign, symptom(s), and/or diagnosis.

Acceptable Diagnoses
- Report the sign, symptom, and/or diagnosis

Resources:

OPTUM Current Procedural Coding Expert 2014
Barnes, Anne, "Colonoscopy: Screening or Surveillance?" AAPC, March 1, 2013

Novitas Updates LCD for Upper GI Endoscopy

States Affected: Pennsylvania, Maryland, New Jersey, Delaware and District of Columbia

Novitas, the Medicare Administrative Contractor (MAC) for these mid-Atlantic states, has published a new Local Coverage Decision titled LCD 34745, UPPER GASTROINTESTINAL ENDOSCOPY (DIAGNOSTIC AND THERAPEUTIC) for services performed after 7/24/2014.

This LCD will be effective only for those Medicare endoscopy services reimbursed by the Novitas MAC. Other areas of the country may have the same, similar or different LCDs concerning upper gastrointestinal endoscopy services.

Should you have any questions on this LCD, please contact your Client Manager who will work with you and our coders, if necessary, for clarification on any section of the LCD.

According to Novitas, endoscopic examinations may be used to evaluate symptoms, identify anatomic abnormalities, to obtain biopsies, or are employed for therapeutic reasons. Per policy LCD 34745, the documentation requirements for Upper Gastrointestinal Endoscopy (diagnostic and therapeutic), state that in order for a provider to report a gastrointestinal endoscopy procedure, documentation must support medical necessity with documentation of at least one diagnosis from the approved diagnosis list (see below).

Please note: Non-specific diagnoses such as unspecified anemia and unspecified abdominal pain are not covered for this procedure and require additional specificity.

Please provide as much detail as possible when documenting the diagnosis and clinical presentation. Important descriptors that should be documented (as applicable) for each patient include:

- Location (i.e., abdominal pain requires specific location)
- Acute or Chronic
- With or without hemorrhage
- With or without obstruction
- With or without perforation

INDICATIONS:

These procedures can only be allowed if abnormal signs or symptoms or known disease are present.

A. Indications which support EGD(s) for **diagnostic** purpose(s) are as follows:

- Upper abdominal distress which persists despite an appropriate trial of therapy;
- Upper abdominal distress associated with symptoms and/or signs suggesting serious organic disease (e.g., prolonged anorexia and weight lost);
- Dysphagia or odynophagia;
- Esophageal reflux symptoms which are persistent or recurrent despite appropriate therapy;

- Persistent vomiting of unknown cause;
- Other systemic diseases in which the presence of upper GI pathology might modify other planned management. Examples include patients with a history of GI bleeding who are scheduled for organ transplantation; long term anticoagulation; and chronic non-steroidal therapy for arthritis;

- X-ray findings of:
    - A suspected neoplastic lesion, for confirmation and specific histologic diagnosis;
    - Gastric or esophageal ulcer; or
    - Evidence of upper gastrointestinal tract stricture or obstruction.

- The presence of gastrointestinal bleeding:
    - In most actively bleeding patients or those recently stopped;
    - When surgical therapy is contemplated;
    - When re-bleeding occurs after acute self-limited blood loss or after endoscopic therapy;
    - When portal hypertension or aorto-enteric fistula is suspected; or
    - For presumed chronic blood loss and for iron deficiency anemia when colonoscopy is negative.

- When sampling of duodenal or jejunal tissue or fluid is indicated;
- To assess acute injury after caustic agent ingestion; or
- Intraoperative EGD when necessary to clarify location or pathology of a lesion.

B. Indications which support EGD(s) for therapeutic purpose(s) are as follows:

- Treatment of bleeding from lesions such as ulcers, tumors, vascular malformations (e.g., electrocoagulation, heater probe, laser photocoagulation or injection therapy);
- Sclerotherapy for bleeding from esophageal or proximal gastric varices or banding of varices;
- Foreign body removal;
- Removal of selected polypoid lesions;
- Placement of feeding tubes (peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy);
- Dilation of stenotic lesions (e.g., with transendoscopic balloon dilators or dilating systems employing guidewires); or
- Palliative therapy of stenosing neoplasms (e.g., laser, bipolar electrocoagulation, stent placement).

C. Sequential or periodic diagnostic upper GI endoscopy may be indicated for an appropriate number of procedures for active or symptomatic conditions.

- For follow-up of selected esophageal, gastric or stomal ulcers to demonstrate healing (frequency of follow-up EGD is variable, but every two to four months until healing is demonstrated is reasonable);
- For follow-up in patients with prior adenomatous gastric polyps (approximate frequency of follow-up EGD's would be every one to four years depending on the clinical circumstances, with occasional patients with sessile polyps requiring every

six-month surveillance initially);
- For follow-up for adequacy of prior sclerotherapy or banding of esophageal varices (approximate frequency of follow-up EGD's is very variable depending on the state of the patient but every six to twenty-four months is reasonable after the initial sclerotherapy/banding sessions are completed);
- For follow-up of Barrett's esophagus (approximate frequency of follow-up EGD's is one to two years with biopsies, unless dysplasia or atypia is demonstrated, in which case a repeat biopsy in two to three months might be indicated); or
- For follow-up in patients with familial adenomatous polyposis (approximately frequency of follow-up EGD's would be every two to four years, but might be more frequent, such as every six to twelve months if gastric adenomas or adenomas of the duodenum were demonstrated).

D. The endoscopic retrograde cholangiopancreatography (ERCP) procedure is generally indicated for certain biliary and pancreatic conditions.

- ERCP is generally not indicated for the diagnosis of pancreatitis except for gallstone pancreatitis;
- ERCP is not usually indicated in early stages or in acute pancreatitis and could possibly exacerbate it;
- ERCP may be useful in traumatic pancreatitis to accurately localize the injury and provide endoscopic drainage;
- ERCP may be useful in pancreatic duct stricture evaluation;
- ERCP may be useful for the extraction of bile duct stones in severe gallstone induce pancreatitis;
- ERCP may be useful in detecting pancreatic ductal changes in chronic pancreatitis and also the presence of calcified stones in the ductal system. A pancreatogram may be performed and is likely to be abnormal in chronic alcoholic pancreatitis but less so in non-alcoholic induced types;
- ERCP may be useful in detecting gallstones in symptomatic patients whose oral cholecytogram and gallbladder ultrasonograms are normal; and
- ERCP may be indicated in patients with radiologic imaging suggestive of common bile duct stones or other potential pathology.

LIMITATIONS:

A. Indications for which EGD(s) are generally not covered by Medicare are as follows:

- Distress which is chronic, non-progressive, atypical for known organic disease, and is considered functional in origin (there are occasional exceptions in which an endoscopic examination may be done once to rule out organic disease, especially if symptoms are unresponsive to therapy);
- Uncomplicated heartburn responding to medical therapy;
- Metastatic adenocarcinoma of unknown primary site when the results will not alter management;
- X-ray findings of:
    - asymptomatic or uncomplicated sliding hiatus hernia;
    - uncomplicated duodenal bulb ulcer which has responded to therapy; or

- Deformed duodenal bulb when symptoms are absent or respond adequately to ulcer therapy;
- Routine screening of the upper gastrointestinal tract;
- Patients without current gastrointestinal symptoms about to undergo elective surgery for non-upper gastrointestinal disease; or
- When lower G.I. endoscopy reveals the cause of symptoms, abnormal signs or laboratory tests (e.g., colonic neoplasm with iron deficiency anemia). Exceptions can be considered if medical necessity for this procedure can be demonstrated.

B. Sequential or periodic diagnostic EGD is not indicated for:

- Surveillance for malignancy in patients with gastric atrophy, pernicious anemia, treated achalasia, or prior gastric operation;
- Surveillance of healed benign disease such as esophagitis, gastric or duodenal ulcer; or
- Surveillance during chronic repeated dilations of benign strictures unless there is a change in status.

Diagnoses Which Meet Medical Necessity for Gastrointestinal Endoscopy
Candidal Esophagitis
Malignant neoplasm of esophagus (specific location required)
Malignant neoplasm of stomach (specific location required)
Malignant neoplasm of duodenum
Malignant neoplasm of pancreas (specific location required)
Secondary malignant neoplasm of small intestine including duodenum
Benign neoplasm of esophagus
Benign neoplasm of stomach
Benign neoplasm of duodenum, jejunum and ileum
Carcinoma in situ of esophagus
Carcinoma in situ of stomach
Carcinoma in situ of other and unspecified digestive organs
Neoplasm of uncertain behavior of stomach intestines and rectum
Neoplasm of unspecified nature of digestive system
Nutritional marasmus
Malnutrition of moderate degree
Other protein-calorie malnutrition
Unspecified protein-calorie malnutrition
Iron deficiency anemia secondary to blood loss (chronic)
Iron deficiency anemia unspecified
Acute posthemorrahagic anemia
Dysphagia cerebrovascular disease
Rupture of artery
Esophageal varices with bleeding
Esophageal varices without bleeding
Esophageal varices in diseases classified elsewhere with bleeding
Esophageal varices in diseases classified elsewhere without bleeding
Achalasia and cardiospasm
Esophagitis
Ulcer of esophagus without bleeding
Ulcer of esophagus with bleeding

Diagnoses Which Meet Medical Necessity for Gastrointestinal Endoscopy
Stricture and stenosis of esophagus
Perforation of esophagus
Dyskinesia of esophagus
Diverticulum of esophagus acquired
Gastroesophageal laceration-hemorrhage syndrome
Esophageal reflux
Esophageal hemorrhage
Esophageal leukoplakia
Tracheoesophageal fistula
Barrett's esophagus
Infection of esophagostomy
Mechanical complication of esophagostomy
Acute gastric ulcer with hemorrhage without obstruction
Acute gastric ulcer with hemorrhage with obstruction
Acute gastric ulcer with perforation without obstruction
Acute gastric ulcer with perforation with obstruction
Acute gastric ulcer with hemorrhage and perforation without obstruction
Acute gastric ulcer with hemorrhage and perforation with obstruction
Acute gastric ulcer without hemorrhage or perforation without obstruction
Acute gastric ulcer without hemorrhage or perforation with obstruction
Chronic or unspecified gastric ulcer with hemorrhage without obstruction
Chronic or unspecified gastric ulcer with hemorrhage with obstruction
Chronic gastric ulcer without hemorrhage or perforation without obstruction
Chronic gastric ulcer without hemorrhage or perforation with obstruction
Acute duodenal ulcer with hemorrhage without obstruction
Acute duodenal ulcer with hemorrhage with obstruction
Acute duodenal ulcer without hemorrhage or perforation without obstruction
Acute duodenal ulcer without hemorrhage or perforation with obstruction
Chronic or unspecified duodenal ulcer with hemorrhage without obstruction
Chronic or unspecified duodenal ulcer with hemorrhage with obstruction
Chronic duodenal ulcer without hemorrhage or perforation without obstruction
Chronic duodenal ulcer without hemorrhage or perforation with obstruction
Acute peptic ulcer of unspecified site with hemorrhage without obstruction
Acute peptic ulcer of unspecified site with hemorrhage with obstruction
Acute peptic ulcer of unspecified site without hemorrhage and perforation without obstruction
Acute peptic ulcer of unspecified site without hemorrhage and perforation with obstruction
Chronic peptic ulcer of unspecified site with hemorrhage without obstruction
Chronic peptic ulcer of unspecified site with hemorrhage with obstruction
Chronic peptic ulcer of unspecified site without hemorrhage or perforation without obstruction
Chronic peptic ulcer of unspecified site without hemorrhage or perforation with obstruction
Acute gastrojejunal without hemorrhage without obstruction
Acute gastrojejunal without hemorrhage with obstruction
Acute gastrojejunal ulcer without hemorrhage or perforation without obstruction
Acute gastrojejunal ulcer without hemorrhage or perforation without obstruction
Chronic or unspecified gastrojejunal ulcer with hemorrhage without obstruction

Diagnoses Which Meet Medical Necessity for Gastrointestinal Endoscopy
Chronic or unspecified gastrojejunal ulcer with hemorrhage with obstruction
Chronic gastrojejunal ulcer without hemorrhage or perforation without obstruction
Chronic gastrojejunal ulcer without hemorrhage or perforation with obstruction
Acute gastritis without hemorrhage
Acute gastritis with hemorrhage
Persistent Vomiting
Acquired hypertrophic pyloric stenosis
Gastric diverticulum
Chronic duodenal ileus
Other obstruction of duodenum
Fistula of stomach or duodenum
Hourglass stricture or stenosis of stomach
Pylorospasm of stomach and duodenum with hemorrhage
Angiodysplasia of stomach and duodenum with hemorrhage
Dieulafoy lesion of stomach and duodenum; hemorrhagic
Other specified disorders of stomach and duodenum
Gastrointestinal mucositis; ulcerative
Diaphragmatic hernia with obstruction
Calculus of gallbladder with acute cholecystitis with obstruction
Calculus of gallbladder with acute cholecystitis without obstruction
Postcholecystectomy syndrome
Unspecified disorder of biliary tract
Acute pancreatitis
Chronic pancreatitis
Cyst and pseudocyst of pancreas
Other specified diseases of pancreas
Hematemesis
Blood in stool
Hemorrhage of gastrointestinal tract unspecified
Gastrointestinal vessel anomaly
Congenital Tracheoesophageal fistula esophageal atresia and stenosis
Other specified congenital anomalies of esophagus
Other specified congenital anomalies of stomach
Jaundice unspecified not of newborn
Anorexia
Loss of weight
Feeding difficulties and mismanagement
Unspecified chest pain
Nausea with vomiting
Vomiting alone
Heartburn
Dysphagia, unspecified
Other dysphagia
Abdominal pain right upper quadrant
Abdominal pain left upper quadrant

Diagnoses Which Meet Medical Necessity for Gastrointestinal Endoscopy
Abdominal pain periumbilic
Abdominal pain epigastric
Nonspecific abnormal findings on radiological and other examination of gastrointestinal tract
Injury to esophagus without open wound into cavity
Injury to esophagus with open wound into cavity
Open wound of pharynx without complication
Foreign body in esophagus
Foreign body in stomach
Foreign body in intestine and colon
Burn of mouth and pharynx
Burn of esophagus
Burn of gastrointestinal tract
Toxic effect of caustic alkalis
Toxic effect of caustic unspecified
Retained cholelithiasis following cholecystectomy
Other digestive system complications
Accidental poisoning by other specified corrosives and caustics not otherwise classified
Accidental poisoning by unspecified corrosives and caustics not otherwise classified
Assault by corrosive or caustic substance except poisoning
Personal history of malignant neoplasm of unspecified site in gastrointestinal tract
Personal history of malignant neoplasm of esophagus
Personal history of malignant neoplasm of stomach
Other digestive problems
Fitting and adjustment of intestinal appliance and device *
Fitting and adjustment of gastric lap band *
Fitting and adjustment of other gastrointestinal appliance and device *
Long term (current) use of anticoagulants
Long term (current) use of steroids
Long term (current) use of aspirin
Long term (current) use of other medications
Follow-up examination following one of the following: chemotherapy, radiotherapy or unspecified or other surgery

* Allowed only in conjunction with the removal of a biliary stent

Medicare Advantage is Growing, not Shrinking

In 2010 (when the ACA was enacted), the CBO projected that ACA payment reductions for Medicare Advantage (commonly called Advantage or MA) would result in 7 million fewer seniors enrolling by 2019.[1] But according to 2014 statistics, the number and percentage of Medicare Advantage beneficiaries are increasing and business for insurance carriers who host Advantage plans is booming.

In fact, nearly a third of Medicare beneficiaries are in an MA plan vs. traditional Medicare and the percentage seems likely to increase. While there are major differences between traditional Medicare and MA, from a patient's perspective, they come down to "how much is the premium?" and "is my doctor in the MA network?" MA plans almost always offer a lower premium (often much lower) but with a limited selection of providers vs. traditional Medicare.

Several factors are contributing to the growth in MA. First, baby boomers new to Medicare are more used to managed care products and working the internet to obtain coverage. Second, the growth in major corporations moving their retiree healthcare to private exchanges[2] provides access to MA plans as well as more traditional MediGap plans. Third, despite ACA language to the contrary, CMS payments to MA insurance providers have actually increased in the past two years. Finally, insurers are beginning to use MA HMO-type plans as a means to control costs.

As a result, physician groups and hospitals need to evaluate their status with payer MA plans to see if they are "in network" and, if not, whether they should be. This is becoming increasingly important since some MA insurers have recently narrowed their networks by dropping major provider groups. With the cost pressures on MA insurers (see below), it seems likely they will continue to narrow their networks as much as possible.

Per the Kaiser Family Foundation Fact Sheet released in April 2014:

- In April, 15.7 million seniors were enrolled in Advantage plans, almost 30% of the 54 million Medicare beneficiaries
- Since the ACA was introduced in 2010, there has been a 41% increase in Advantage enrollees (from 11.1 million in 2010)
- MA enrollment has tripled since 2003 when 5.3 million seniors were enrolled
- 64 percent of the MA beneficiaries are enrolled in an HMO product and 23 percent are in local PPO
- Medicare payments to MA plans are projected to total $156 billion in 2014, accounting for 30% of total Medicare spending

Medicare Advantage Insurers

The MA market is dominated by large insurers: Humana, UnitedHealth Group, Aetna, Cigna, Wellpoint and Kaiser Permanente. Together these six plans control more than half of the Advantage market with 9.2 million enrollees. No other insurer covers more than 400,000 Advantage customers.[3] The larger companies are growing their Advantage plans and over the years, smaller plans may struggle to keep their Advantage rates low, resulting in mergers or the larger companies buying their Advantage plans.

Insurers who do a good job of keeping costs down while providing quality care, should be able to keep and add to their Advantage beneficiary base. Per a study performed by HealthPocket, plans can obtain more money from CMS by improving their star rating. Beginning in 2015, only plans that receive at least four stars will be eligible for CMS bonuses. In 2014, 38 percent of Advantage plans received at least four stars, up from 28 percent in 2014.

Recent changes have affected at least three insurers and their beneficiaries this year and into 2015.

- UnitedHealth has recently dropped providers in Alabama stating they do not consider their restructuring to fall into the narrow network category but that UnitedHealth is building more "focused" networks. The drop came in the middle of the year leaving many patients scrambling to find new coverage. Last year patients and physicians were angry when UnitedHealth reduced some networks causing many customers to lose access to their doctors resulting in lawsuits filed against the insurer in two states.

- Humana lost a large provider contract in Minnesota when the practice shared the concerns of Minnesota's Attorney General that Humana was overcharging its beneficiaries and inappropriately denying claims.

- MVP Health Care is discontinuing two of its five plans which could affect 17,000 beneficiaries. The three remaining plans will require higher co-pays and, depending on which plan is chosen, could have substantially higher premiums.

How does Medicare Advantage work?

Advantage is still an attractive option for millions of seniors and disabled Americans because it offers comprehensive coverage, and generally, a more generous benefits package than traditional Medicare. By law, Advantage plans must provide at least the same benefits as traditional fee-for-service (FFS) Medicare Parts A and B. But unlike traditional Medicare, Advantage plans must also put a cap on beneficiaries' out-of-pocket costs.

Advantage also provides patients with a variety of plans (ranging from managed care and private fee-for-service plans to "special needs plans"); a network of doctors, hospitals, and other medical professionals (usually more limited than traditional Medicare); along with catastrophic coverage protection and a wider array of health benefit options, such as drug or vision coverage. Advantage plans have also been proactive in offering care coordination and case management services. These plan offerings have resulted in higher enrollee satisfaction and significant savings for seniors, particularly on out-of-pocket medical costs.[4]

Medicare Advantage premiums

Medicare pays Medicare Advantage plans a capitated (per enrollee) amount to provide all Part A and B benefits plus a separate payment for providing prescription drug benefits under Medicare Part D. Federal payments to Advantage plans have always exceeded payments to traditional Medicare for the same mix of services. Since 2006, Medicare has paid plans under a bidding process based on estimated costs per enrollee for services covered under Medicare Parts A

and B. The bids are compared to benchmarks which are the maximum amounts Medicare will pay a plan in a given area.

Enrollees pay the difference between the benchmark and the bid in the form of a monthly premium, in addition to the Medicare Part B premium unless the bid is lower than the benchmark. In this case, the plan and Medicare split the difference between the bid and the benchmark; the plan's share is known as a "rebate," which must be used to provide supplemental benefits to enrollees. Medicare payments to plans are then adjusted based on enrollees' risk profiles.

Advantage premiums, like most others, have been rising but not spiking. Actually in 2014, the Advantage plan premiums were less than 2013. In 2014, the average monthly premium is $49, down from $51 in 2013 and many Advantage plans require no premium. However, the average cap on out-of-pocket costs has increased by more than 10% for 2014, to an average of $4,797; 41 percent of plans have out-of-pocket limits of $5,000 or more.[5]

In 2010, the ACA tried to bring Medicare Advantage plans into line with the cost of traditional Medicare by revising the methodology for paying plans and by reducing the benchmarks. For 2011, benchmarks were frozen at 2010 levels and reductions in benchmarks were slated to be phased-in between 2012 and 2016.

Medicare Advantage costs taxpayers more

Before the ACA, Advantage plans received federal funding that averaged 14% more than the cost of treating the same patients enrolled in traditional Medicare. But since 2012, with the ACA cuts, these payments have dropped from an average of 7% higher to 4% higher than traditional Medicare fee-for-service payments.[6]

This projected reduction in funding caused many, particularly conservatives, to say that Medicare Advantage plans were threatened and seniors would no longer have affordable access to the plans. Insurers who led intense lobbying campaigns against payment reductions said the Medicare Advantage plans would sustain far deeper cuts when other factors are taken into account, such as Medicare cuts made as a result of budget sequestration and the health law's tax on health insurance premiums.

As noted, the original ACA plan was to reduce the benchmarks and pay less to the private insurers who hosted the Advantage plans in order to reduce Medicare spending. However for the second year in a row, instead of cutting funds to Advantage plans, the Obama administration increased funding. On April 7, 2014, the administration turned a proposed 1.9 percent cut to 2015 Medicare Advantage health plans into a .4 percent increase after heavy lobbying from insurers and Capitol Hill. It was the second-straight year that the Medicare agency transformed a proposed rate cut into a raise. (In 2012, the administration initially proposed cuts of 2.2 percent for 2014, but reversed the cuts and increased the rate 3.3 percent.)

However, despite last year's increase, insurers say they still saw their Medicare Advantage reimbursements shrink about 6 percent in 2014 plans. And Moody's Investor Service said even after this April's payment boost, the final 2015 rates are a "credit negative" for Medicare Advantage insurers, who are anticipating an average reimbursement reduction between 3 percent and 4.5 percent next year.[7]

Even with the "credit negative," the large insurers hosting Advantage plans are doing well and projections show continued increases in MA enrollees over the next few years.

Will the Boom Last?

Some speculate that if the Advantage plans are cut for 2016, costs to seniors will continue to go up, their benefits may be reduced and they may have fewer choices of providers and fewer coverage options. This could send beneficiaries back to traditional Medicare or cause many to change their Advantage plans. Consumer advocates say Medicare Advantage works only if seniors shop for a new plan each year because the plans change so often. But too often, seniors stay with same plan which leads them to pay more than they need to.[8]

The major tradeoff that insurers and consumers face is the makeup of each Medicare Advantage network. Too narrow and consumers won't sign up. Too broad and premiums could be too expensive. Consumer advocates hope that the growth in exchanges will lead to more MA competition. Based on recent experience, most observers expect to see a continued expansion of MA plans with a continued growth in the "market share" of Medicare Advantage.

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[1] Demko, Paul, "Despite Cuts, Medicare Advantage Enrollment, Insurers' Stocks, Still Surging," ModernHealthcare, April 5, 2014.
[2] GE, IBM and Time Warner announced private retiree exchanges in 2013 for plan year 2014. Others, including AT&T have announced private retiree exchanges for plan year 2015.
[3] Demko, Paul, "Despite Cuts, Medicare Advantage Enrollment, Insurers' Stocks, Still Surging,"ModernHealthcare, April 5, 2014.
[4] Moffit PhD, Robert E., and Senger, Alyene, "Progress in Medicare Advantage: Key Lessons for Medicare Reform," The Heritage Foundation, September 4, 2014.
[5] Gold, Marsha, "Medicare Advantage 2014 Spotlight: Plan Availability and Premiums," The Henry J. Kaiser Family Foundation, November 25, 2013.
[6] Michel, Robert, "Higher Enrollment in Medicare Advantage Plans Means that More Local Clinical Laboratories and Pathology Groups Lose Access to these Patients,"Dark Daily, August 25, 2014.
[7] Millman, Jason," Medicare Reversed Payment Cuts, and not Many are Happy About It," Washington Post, April 14, 2014
[8] Galewitz, Phil, "Impact Of Medicare Advantage Cuts On Seniors Sharply Disputed," Kaiser Health News, February 24, 2014.

Site-Neutral Payments Are Still on the Table

If you thought the attempts to institute site-neutral payments were going away, think again. You may remember that in the proposed 2014 Medicare Physician Fee Schedule (MPFS), CMS wanted to limit the amount paid for a service in the physician office setting to the amount paid for the same services when provided in a hospital outpatient department or ambulatory surgery center (ASC). However, after many negative comments from the health care community, CMS did not finalize that proposal nor did it mention the topic in the 2015 Proposed Medicare Physician Fee Schedule.

However, the interest in identifying and addressing the site payment differences continues. The Robert Wood Johnson Foundation published an excellent health care policy brief [1] in July explaining the origin of these differential payments and the debate over the very different approaches that have been proposed for developing site-neutral payments. Much of the information in this article is taken from that brief – see footnote below.

Medicare uses several different payment systems to set payment rates for Medicare services, and location of services is one of them. As Medicare and the whole health care system looks for ways to reduce costs and provide quality of care, tackling the payment differences, which are sometimes substantial, for the same services performed in different site types could be still be an important line item reduction in Medicare's books.

The controversy around site-neutral payments stems from recent shifts of services from the physician's office to the hospital out-patient department. MedPAC, in their March report to Congress, stated that the share of physician visits (evaluation and management services) and certain diagnostic cardiology procedures (particularly echocardiograms) performed in a hospital outpatient department setting increased by 8 percent between 2010 and 2011 and by 9 percent between 2011 and 2012. Because these are higher paid services in the outpatient department setting, this increases Medicare spending and at this time, with no proof that the quality of care is any better. At the same time, the share of those services administered in free-standing physician offices decreased by 1 percent each year.

The two main entities involved in Medicare rate settings are The Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC). Although, in many cases they are on the same page with reimbursement issues, they are taking very different approaches to eliminate differential payment for certain services.

The CMS Proposal

CMS states that Medicare typically pays more for the same services when it is provided in a hospital outpatient department than in a physician's office and justifies it because hospitals incur higher costs to maintain 24/7 operations and must meet legal obligations to provide care to people needing emergency medical treatment. However, the separate methodologies (the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (HOPPS)) have produced rates for some 200 procedure billing codes where the physician fee schedule rate is higher than the outpatient rate: CMS believes these rates are the result of inaccurate data used to determine costs under the MPFS.

The MedPAC Proposal

MedPac recommends limiting payments to hospital outpatient departments stating that "Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries." MedPac proposed to set payment rates for evaluation and management services and other types of services in hospital outpatient departments at the same rate that is paid under the MPFS. They also offered an alternative approach of equalizing payment rates between hospital outpatient departments and ambulatory surgical centers for certain services.

Other indications of the continued discussions on site-neutral payments were evidenced this year:

- In March, MedPAC, in its annual report to Congress, evaluated 450 ambulatory payment classifications and found 66 that did not require emergency standby capacity, did not have extra costs associated with greater patient complexity and did not need the additional overhead that comes with services that must be provided in a hospital setting. They concluded that aligning HOPPS payments with MPFS rates for these services would reduce Medicare and beneficiary cost sharing by $1.1 billion.

- In April, the OIG (Office of Inspector General) recommended CMS reduce hospital OPPS rates for ASC-approved procedures to ASC levels for low-risk patients stating that move could save Medicare as much as $15 billion from 2012 through 2017. The Lower OPPS rates could also save beneficiaries $2 billion to $4 billion in copays and coinsurance during the same time period. CMS did not concur with these recommendations.

- Congress is requiring that long-term care hospitals be paid a rate comparable to the inpatient prospective system rate for patients that do not meet certain criteria. This rate adjustment will take place in 2016 and CMS should include details about how the adjustment will be applied in its rulemaking next year.

CMS may still be able to revisit its issue with reducing office based rates: as part of the Protecting Access to Medicare Act of 2014 on April 1, 2014 ("the SGR fix"), Congress expanded the types of information CMS can use to determine costs under the physician fee schedule. CMS could also attempt to change the office rates via the "potentially misvalued codes" provision of the physician fee schedule.

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[1] Health Affairs and the Robert Wood Johnson Foundation, Health Policy Brief, July 24, 2014

Patient Engagement

Engaging patients is at the foundation of nearly every current trend in healthcare and one of the most important components of health care reform. Health Affairs defines patient engagement as a "concept that combines patient activation (patient's knowledge, skills, ability, and willingness to manage his or her own health or care) with interventions designed to increase activation and promote positive patient behavior, such as obtaining preventive care or exercising regularly." [1]

The EHR Incentive/Meaningful Use program lists patient engagement as one of its core tenets by developing measures to ensure patient accessibility to their health records. And with the introduction of smartphone healthcare apps and mobile fitness and health monitoring devices, the wave of patient engagement or consumerism in health care is growing. Access to these devices and the internet to find out more about managing their health has led to patients' increasing desire to communicate and receive personal health data from their providers wherever and whenever they choose.

A 2013 Health Affairs article stated a "growing body of evidence demonstrates that patients who are more actively involved in their health care experience better health outcomes and incur lower costs." The Robert Wood Johnson Foundation has reported that patients not engaged in their own care can cost 21 percent more than "highly engaged patients."[2] In truth, it all centers on each point of the healthcare triangle: reducing costs, improving outcomes, and better engaging patients. The reality is that the first two are inherently tied to the third.[3]

In addition to the EHR program, new payment and delivery models, such as risk-based contracts, Patient-Centered Medical Homes and Accountable Care Organizations are springing up across the country – all programs designed to lower health costs and provide patient accessible quality healthcare. By taking on risk with bundled payments, providers must be able to affect patients' behavior after they leave the office, or they will exceed the reimbursement rate for their care.

Medical practice has been gradually increasing its focus during the past decade from a more authoritative/paternal model to a more collaborative/consumer model. Hospitals, doctors and public-health officials are calling upon patients as consumers to become more active in their own care decisions by keeping track of their medical data, seeking preventive care and staying on top of chronic conditions.

Consumers now have a greater personal financial state in their healthcare as well. The public health insurance marketplace, created by the Affordable Care Act, as well as the private insurance marketplace, enable consumers to annually choose from multiple health plan options and provider networks. But understanding these health plan options is complex and demands much more consumer evaluation of costs, what they are getting for the cost of their coverage and if their preferred providers are in the plan's network.

In order to accommodate this patient interest and engagement in their healthcare, medical practices must implement strategies to engage patients and include them and their families in decisions about their health.

Technology will be part of these strategies. One stategy is to make sure people have easy access to their medical records online. Reading and understanding one's own health record enables patients to have more informed conversations with their physicians. With all the new fitness and health apps, consumers can now plug in data from their own medical record, such as generating a fitness regimen that takes into account a knee injury, weight and blood pressure.[4]

Web-based patient portals have been installed in many health care institutions allowing patients to book appointments, obtain referrals, request prescriptions, pay their medical bills, obtain lab results, radiology reports, physicians' notes and see their own medical records. Many systems allow patients to check their data to make sure it's accurate.

It has been suggested that organizations should strongly consider open systems that can integrate with their current financial and clinical system, but also capture data from unaffiliated entities and patients. "Providers that are first to integrate the various information sources – from pharmacists, ambulatory centers, clinics, and so forth – will find themselves central to a consumer's health and will be rewarded with increased loyalty and more effective interactions with patients."[5]

All technology must be simple to use and understand. The portals should have a dedicated mobile application that allows users to access their PHI and perform common tasks such as appointment scheduling or requesting a prescription renewal.

Yet, according to a survey from consulting firm Technology Advice, 40 percent of people who had seen a primary care physician within the last year did not know whether that doctor offered a portal. Only 9 percent said their physicians followed up with them after the visit via a portal, and 48 percent stated there was no follow-up. Certainly providers must provide patient education concerning the availability and usage of patient portals and other devices offered by the provider or institution.

However, significant barriers exist for many patients to access and understand their patient health information. The National Assessment of Adult Literacy (NAAL), which measures the health literacy of adults living in the United States, reported that only 12% of the population is considered proficient in healthcare literacy. A patient's degree of engagement may be affected by such factors as cultural differences, sex, age, and education.

So, it is not only important for healthcare entities to provide access to their patients' health information but providers may need to understand that specific competencies, such as language skills or an awareness and understanding of religious beliefs may be required on the part of physicians to effectively engage patients with diverse cultural backgrounds and socioeconomic status. Physicians should be ready to take on the role of educator. Shared-decision making offers an option for better educating patients about their conditions. Participation in the EHR meaningful use program assists physicians because its requirements include engaging patients and families in decision making and providing them with their health records and clinical summaries they can view and share with other physicians. The requirements also specify that a percentage of patients must actually use the information, which gives physicians a reason to encourage them to do so.

Besides taking the time to review findings and outcomes of tests, physicians must understand

where the patient is coming from and what they want to do. The patient needs to be engaged with personalized information and advice but challenges remain in figuring out two way communications will work through portals and other electronic means.

Healthcare organizations that install technology and provide strategies and workflows designed to assist patients in understanding their health care and condition will be competitive and will survive in this new health care age. The time is now to jump on the patient engagement bandwagon if you have not already done so.

Resources

Here are some resources that can be used by physicians and/or recommended to their patients.

The Blue Button

The Blue Button first appeared in 2010 on a patient portal where veterans could log-in and download their health records. Since then, many other organizations including physicians, hospitals, health insurance plans, retail pharmacies, labs, etc. have implemented Blue Button to make it easier for people to access their vital health information online.

Blue Button allows patients to see, download and keep their personal health data by clicking the "Blue Button" on a secure Internet site. Patients can then choose to share their data with their physicians or family members or make it available if emergency treatment is needed. Blue Button downloads are delivered in text files that can be downloaded, read, stored and printed on any computer without special software. Patients can also authorize use of a Blue Button transfer of their medical data from a treating physician to another medical provider.

In the Spring of 2013, The Centers for Medicare and Medicaid Services launched the Blue Button Connector which allows patients to download their health information to their computer or their mobile device.

Medicare beneficiaries can also view and download their Medicare claims through the Medicare Blue Button which now covers three years of a patient's health history, including claims information on services covered under Medicare Parts A and B, and a list of medications that were purchased under Part D. This service is also available to Veteran's services and the Indian Health Service.

National Coordinator for Health IT Karen DeSalvo announced at the 2014 Consumer Health IT Summit this September that there will soon be a new Blue Button campaign, that's "gonna really explode."[6]. A new Blue Button toolkit was also unveiled at the event.

Payers including UnitedHealthcare, Aetna Inc. and Humana Inc. offer a Blue Button link that lets members download personal health records into a single file, and retail pharmacy chains are in various stages of using Blue Button to let customers download prescription histories.

Robert A Wood Johnson Foundation – Patient Engagement Resource Guide

This guide provides a list of patient-friendly materials to help people chose high-quality care, manage their health care conditions, and make informed decisions regarding hospital and

emergency care. The guide also provides clinicians with resources to engage patients in their own care and involve them in other aspects of health care delivery.

The article in the **Wall Street Journal** listed the following two products that providers can recommend to their patients to assist them in monitoring their health.

Partners Health Care – Wellocracy (website to help people review the health trackers and mobile apps on the consumer market.)

Healthwise, Inc. – offers solutions to physicians to share health education solutions, technology, and services with their patients. One of the popular products is "information prescriptions" in the form of a video, brochure or interactive decision tool to help patients deal with a health problem.

[1] Health Policy Brief, "Patient Engagement," Health Affairs, February 14, 2014
[2] Versel, Neil, "Models of Patient Engagement," HealthcareIT News, August 22, 2014
[3] Watson, Zach, "What Every Provider Needs to Know about Patient Engagement,"Technology Advice, May 13, 2014.
[4] Landro, Laura, "The Health-Care Industry Is Pushing Patients to Help Themselves," Wall Street Journal Online, June 8, 2014.
[5] Davenport, Vern, "Is Healthcare Really Ready for Consumerization?" Government IT Health, August 7, 2014. (This is a quote in the article from McKinsey & Company from a 2010 article in the American Journal of Managed Care.)
[6] Dvorak, Katie, "DeSalvo Touts Iinteroperability, Blue Button at Consumer Health IT Summit." Fierce Health IT, September 15, 2014.

Compliance Requirements... Don't be a Target

Many of our clients routinely ask about their compliance responsibilities. Many clients believe that their written compliance plan (that complies with Office of Inspector General, CMS for Medicare and Medicaid and HIPAA Privacy and Security regulations) fulfills their obligations. Let me assure you that this is not the case.

It doesn't matter whether your compliance plan (the document) was professionally done by an attorney or whether you developed one internally; the compliance plan must be an "effective compliance and ethics program". What does that mean to you? There are a number of activities needed to bring your compliance plan to life.

Developing the compliance plan document, and then putting it on the shelf, will work against you in the event of a federal or state government review of your practice (due to patient complaint, whistle blower, or other third party entity). Oh, and don't forget that these plans should be updated as regulations change. If you have a written compliance plan; in what year was it completed? Has it been updated? Compliance guidance states that compliance plans should be reviewed and updated as necessary, at least annually, or as regulations change.

An effective compliance and ethics program protects your practice by detecting and preventing improper conduct and promoting adherence to your practice's legal and ethical obligations. In 1991, the U.S. Sentencing Commission established the most recognized standards for an effective program within its Sentencing Guidelines Manual. These Guidelines are closely aligned with the principles provided in OIG's Compliance Guidance for Physician Practices. While there is no "one-size-fits-all" program for every practice, there are 7 core elements that must exist in an effective program. They include:

- Compliance officer
- Written plan (policies and procedures)
- **Training and education**
- Lines of communication
- Auditing and monitoring
- Exception/incident procedures
- Response and corrective action

What can you do to promote compliance in your practice if you don't have an effective compliance program or a written compliance plan? A simple and effective way to begin is to engage in professional compliance training which will immediately raise compliance awareness for staff and physicians, and it fulfills one of the 7 core elements of an effective compliance program.

AdvantEdge offers a Web-based Compliance Training Program that can be accessed from anywhere at any time and it fulfills the annual training obligations. It is subscription-based so there is no software to purchase or system to maintain. The educational curriculum is always up-to-date eliminating home-grown compliance educational program development challenges. Upon completion of training, you will print out a proof of training certificate which demonstrates that you have completed annual training requirements.

How much will this cost? The subscription considers the number of users (administrative staff,

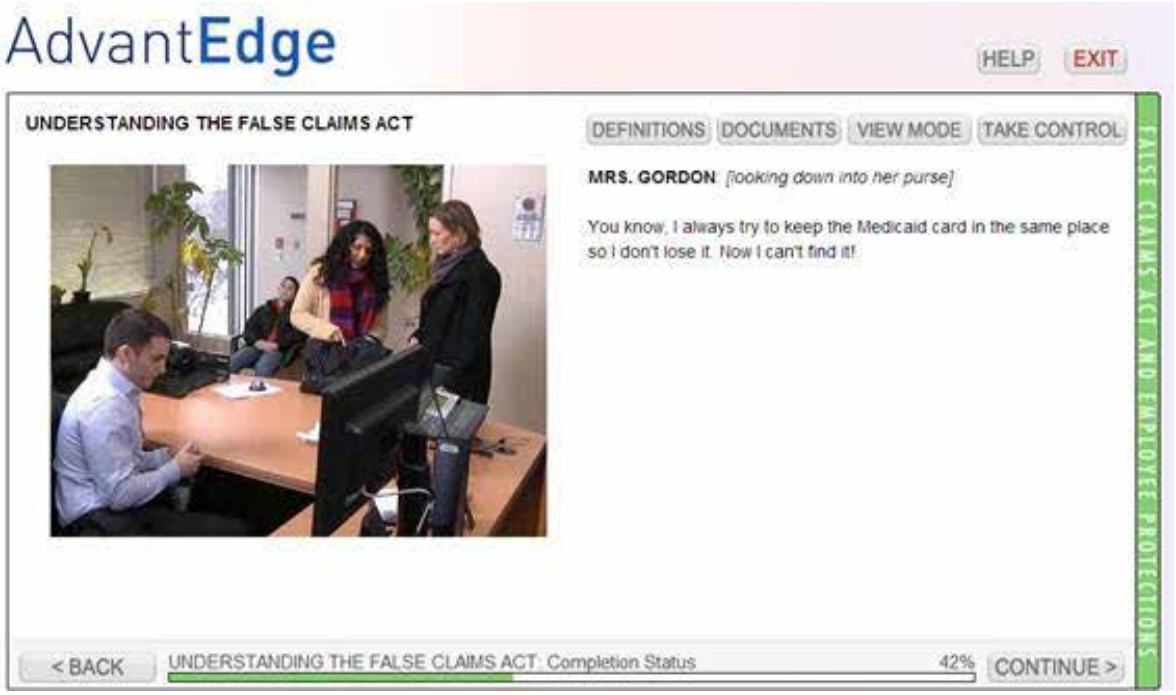
physicians, non-physician practitioners) that will receive training.

- 1 to 10 users – $1,050 per year
- 11 to 50 users – $3,050 per year

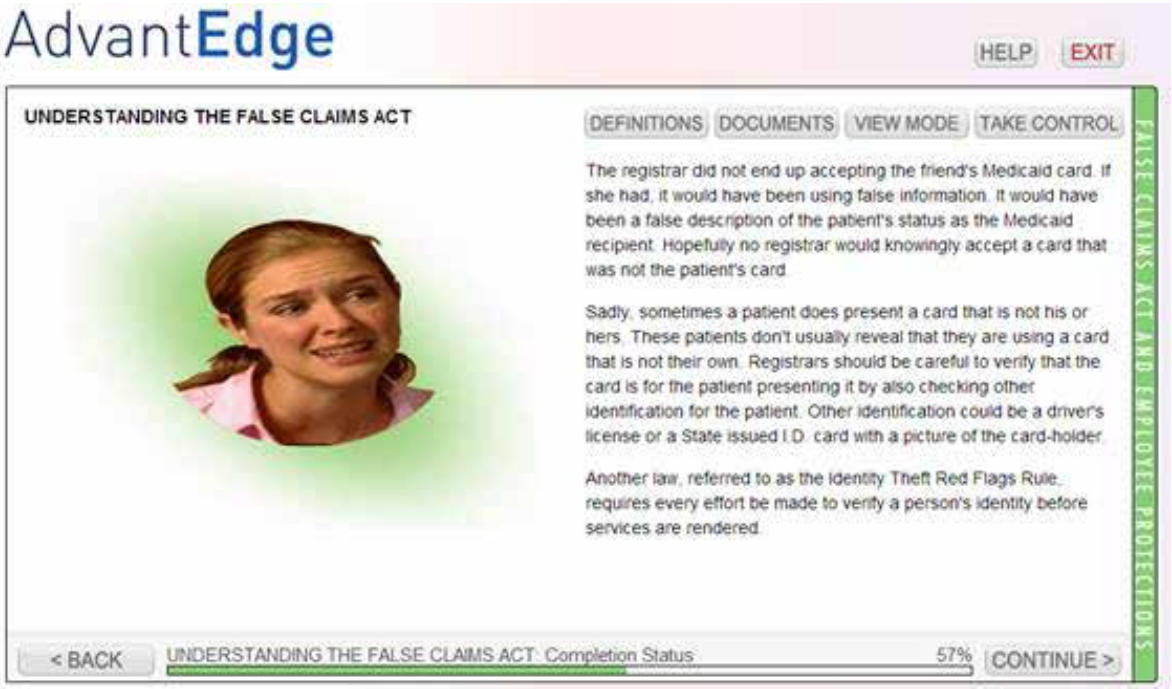
If we use an example of a 5-user subscription, it will cost $210 per user/year or calculated another way $87.50 per month for up to 10 users.

You don't want to be the practice that makes the headlines. It is not the boldly non-compliant physician that always makes the news. There are many innocent mistakes that become compliance issues because the regulation states "or you should have known."

Sample of course content: Understanding the False Claims Act vignette (opening conversation)



Closing Summary of Undesrtanding the False Claims Act vignette



Below are two examples of innocent non-compliant HIPAA activity:

Physician Revises Faxing Procedures to Safeguard PHI Covered Entity: Health Care Provider Issue: **Safeguards**

A doctor's office disclosed a patient's HIV status when the office mistakenly faxed medical records to the patient's place of employment instead of to the patient's new health care provider. The employee responsible for the disclosure received a written disciplinary warning, and both the employee and the physician apologized to the patient. To resolve this matter, OCR (Office for Civil Rights) also required the practice to revise the office's fax cover page to underscore a confidential communication for the intended recipient. The office informed all of its employees of the incident and counseled staff on proper faxing procedures.

Private Practice Revises Access Procedure to Provide Access Despite an Outstanding Balance Covered Entity: Private Practice Issue: **Access**

A complainant alleged that a private practice physician denied her access to her medical records, because the complainant had an outstanding balance for services the physician had provided. During OCR's investigation, the physician confirmed that the complainant was not given access to her medical record because of the outstanding balance. OCR provided technical assistance to the physician, explaining that, in general, the Privacy Rule requires that a covered entity provide an individual access to their medical record within 30 days of a request, regardless of whether or not the individual has a balance due. Once the physician learned that he could not withhold access until payment was made, the physician provided the complainant a copy of her medical record.

Two examples of improper billing activities (regulatory compliance) that resulted in fraudulent

claims being submitted to payors:

Provider was fined $400,000 and permanently excluded from participating in Medicare by overstating face-to-face time with patients. Providers have been known to consider face-to-face time as time required to document the medical record which is not correct.

Provider paid $435,000 and entered a 5-year Integrity Agreement for submitting claims that were not supported by accurate patient medical records. How many times have you heard from government authorities "not documented; not done."

Not having an effective compliance program (an on the shelf compliance plan or no plan at all) may result in the following:

- Increased fines and penalties
- Exclusion from Medicare and Medicaid programs
- Probation, home confinement or incarceration

We can help make regulatory and HIPAA compliance a reality for your practice by arming you and your staff with the latest information and educational resources to ensure that you are knowledgeable, well-prepared, and current with healthcare regulations including HIPAA and federal and state laws. See our brochure and consult with your AdvantEdge Client Manager or call Jeanne Gilreath directly at 908.279.8104 or email jgilreath@ahsrcm.com for further information.

HIPAA Breach Awareness: Patient Demographics

Are You Validating Your Patient Demographics EVERY TIME?...If not, you may be putting your practice under the HHS microscope for HIPAA breach disclosures. Consider this scenario; Mary Smith does not feel well and visits her longtime local internist. The receptionist recognizes Mary, welcomes her and advises that someone will be out shortly. No validation of address or insurance information is performed. Mary meets with Dr. Sweet who determines that Mary is truly ill and needs further testing. Mary is referred to laboratory and imaging facilities. Mary finishes with Dr. Sweet and obtains a follow up appointment with the receptionist, then pays her co-pay for today's visit.

Within days Mary's insurance company is sent a claim that is processed, with a balance due of $75. A statement is generated to Mary's address on file. Unfortunately, Mary moved across town the month before her doctor visit. She never mentioned the move and the receptionist never asked during the two face-to-face opportunities to do so.

Mary is very busy and pays most of her bills online, so she never thought to advise the Post Office of an address change, after all – she does not need any more junk mail! But sadly, this is the only address the doctor has on file.

The new tenant in Mary's old apartment receives mail Saturday afternoon and inadvertently opens it; coincidently he is also a patient of Dr. Sweet. He realizes this mail is not intended for him so he asks a neighbor in the building if they ever see Mary, because he has a bill for her. Monday morning Mr. New Tenant phones the doctor's office to let them know Mary doesn't live there anymore.

In the meantime, Mary had been grocery shopping Sunday evening and ran into the old neighbor, who asks how Mary is feeling. "What? I'm OK, why do you ask?" On and on and on... you can see how this simple wrong address scenario can get out of control quickly and how a patient may get upset.

Mary was very upset when she found out that her old neighbor knew she went to the doctor. Mary also phoned the office on Monday and threatened to sue and advised that she was going to report the doctor for disclosing her medical visit. All of this could have been avoided if the receptionist had asked Mary to state her demographic information so she could verify it with what was in the system.

(Note: We realize that Mr. New Tenant should not have opened mail that did not have his name on it, but it did have his address, and it was his doctor's office also. He didn't notice that the name in the window was not his.)

The scenario above is, unfortunately, not unique. Worse, it is a reportable breach to the Office of Civil Rights (OCR) at the Department of Health and Human Services! Mary believes she has been caused significant harm by the release of her PHI to a non-authorized person. It is a breach of non-secured PHI and it also necessitates a mini risk analysis by the covered entity. Situations like this, at a minimum, show the need for practices to have established patient demographic validation procedures performed each and every time a patient steps into the

office or while making the appointment. Hospital-based groups need to be aware of their hospital's admit process for capturing demographics and assure that their downstream billing and other patient contact processes (e.g. copies of reports) carefully verify demographics.

Registration/check-In errors can lead to HIPAA breaches, lost revenue, denied insurance claims, returned mail, aging A/R for self-pay balances and additional staff time. These inaccuracies, whether intentional or not, have a big impact on all healthcare organizations.

Under the new HIPAA Final Omnibus Rule, covered entities and business associates responsible for violating HIPAA privacy and security rules by failing to safeguard patient protected health information can face up to $1.5 million in annual fines.

A Covered Entity or a Business Associate must report HIPAA breaches to the OCR, at a minimum, once a year within 60 days from the end of the calendar year (45 CFR 164.402, 404 and 408).

But...Does a Billing Statement Really Contain Enough Information to Get Me in Hot Water?

You may wonder if the above scenario isn't a little bit of a stretch ... what information ***REALLY*** needs to be compromised to create a HIPAA breach. Two more simple scenarios help us understand;

1. A provider sends a patient a letter that includes the patient's name and address, patient number, admission date, account balance, and the provider's name.

2. A provider sends a letter that includes the patient's name and date of birth, patient number, date of service, medical record number, and the provider's name.

If one of the above letters is sent to someone other than the patient, is this considered a breach of PHI that requires patient notification? The short answer is "Yes".

PHI is defined as individually identifiable health information. A strict interpretation and an "on-the-face-of-it" reading would **classify the patient name alone as PHI if it is in any way associated with the provider**. (Pursuant to 45 CFR 160.103, PHI includes demographic information received by a healthcare provider relating to the provision of healthcare). If the name of an individual is associated with a medical group and/or provider that delivered healthcare, it is demographic information and is considered PHI.

The additional information confirms that the content of the letter is PHI even though the letter does not specifically mention the health condition of the patient.

The regulation does not require a data set to include a certain number of identifiers to be considered PHI. **It specifically states that if information identifies an individual, it is PHI.**

The information included in the two example letters is clearly PHI. Sending the letter to the wrong individual would be considered a breach of unsecure PHI. After conducting a risk assessment to determine whether sending the letter to the wrong individual will cause harm to the affected patient, the provider would be responsible for determining whether to notify

the patient. **The provider must document its actions regardless of whether the incident is a notifiable breach (45 CFR 164.400–164.414).**

Over the past few years we have observed that many more patients are on the look-out for fraud. There have been instances where a seemingly 'simple' wrong address has led to patients notifying Medicare/HHS/OCR/OIG believing they are being targeted in a scam or some sort of deceptive billing practice. Patients are more educated than ever and are picking up the phone and making complaints to agencies before ever contacting the billing company or provider's office.

Don't Forget State Privacy Requirements

Beyond HIPAA there exists another universe of breach notification requirements in the 46 states that have data breach notification laws. Risk assessments must therefore include not only HIPAA requirements, but also the requirements of an organization's respective state laws.

Conclusion

The patient check-in process (and check out where applicable) at a physician office or a hospital is an opportunity to update and collect information about the patient. This face-to-face time with the patient should be utilized each and every time to validate demographic information. Covered entities and business associates must stay on their toes and evaluate not only what will constitute an inappropriate use or disclosure of PHI but also what can be done to ensure that appropriate policies and procedures are in place to avoid inquiries and reprimands from government agencies.

Beware of the -59 Modifier as of January 1, 2015

Although we have published this latest CMS announcement in our recent newsletters, we want to ensure that everyone is aware of the -59 modifier change, effective January 1, 2015. Since it is widely-used, improper use can have a significant impact on reimbursement (from delays or denials).

CMS has recently announced changes to the use of the -59 modifier which could impact medical billing submissions and provider reimbursement. Per CMS, due to chronic overuse of modifier -59 (Distinct Procedural Service), they have created a new series of modifiers which provide more specificity of the distinct procedural service. The -59 modifier is the most widely used HCPCS modifier and is used in a wide variety of circumstances, such as to identify:

- A separate encounter;
- A separate anatomic site; and
- A distinct service

However, CMS states the -59 modifier often overrides the edit in the exact circumstance for which it was created in the first place, and is used;

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment and so, effective January 1, 2015, CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 .

- XE Separate Encounter, a service that is distinct because it occurred during a separate encounter
- XS Separate Structure, a service that is distinct because it was performed on a separate organ/structure
- XP Separate Practitioner, a service that is distinct because it was performed by a different practitioner
- XU Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. It is unclear at this time if other payors will adopt the new modifiers.

For our physicians who code their own services, it will be important to understand and use the four new modifiers to describe your services. For those clients who submit medical reports to AdvantEdge for coding, please include in your dictation information that will allow our coders to distinguish which modifier should be appended to your services if applicable.

References: MLN Matters® Number: MM8863 & CMS Transmittal 1422.

ICD-9 to ICD-10 Conversions: Pressure Ulcers

Diagnosis: Pressure Ulcers

Pressure ulcers include bed sores, decubitus ulcers, plaster ulcers, pressure areas, and pressure sores.

ICD-9 Code(s): 707.00 – 707.09

Listed Under Diseases Of The Skin And Subcutaneous Tissue 680-709 → Other Diseases Of Skin And SubcutaneousTissue 700-709 →Chronic ulcer of skin 707-

In ICD-9, two codes are assigned for ulcers, the site of the ulcer and the stage of the ulcer. The site of the ulcer would be sequenced first, followed by the pressure ulcer stage.

ICD-9 Pressure Stages:

–707.20—Pressure ulcer, unspecified stage

–707.21—Pressure ulcer, stage 1.

–707.22—Pressure ulcer, stage 11.

–707.23—Pressure ulcer, stage 111.

–707.24—Pressure ulcer, stage 1V.

–707.25—Pressure ulcer, unstageable

ICD-10 Code(s) L89.000 – L89.899

Listed Under: Diseases of the skin and subcutaneous tissue L00-L99 → Other disorders of the skin and subcutaneous tissue L80-L99 → Pressure ulcer L89-

In ICD-10, the two codes have been combined into one code that includes both the site and stage of the ulcer. ICD-10 further breaks down the codes according to the side of the body.

See all pressure ulcer ICD-10 codes following the chart.

Diagnoses in shaded areas are titles only and are not billable codes

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Pressure Ulcer	707.0	L89	**Pressure Ulcer**
Pressure Ulcer of ***Elbow***	707.01	L89.000 – L89.009	Unspecified elbow and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.010 – L89.019	Right elbow and stage
		L89.019 – L89.029	Left elbow and stage
Upper back (shoulder blades)	707.02	L89.100 – L89.109	Unspecified part of back and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.110 – L89.119	Right upper back and stage
		L89.120 – L89.129	Left upper back and stage
Lower Back (coccyx, sacrum)	707.03	L89.130 – L89.139	Right lower back and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.140 – L89.149	Left lower back and stage
		L89.150 – L89.159	Sacral region and stage
Pressure Ulcer of ***hip***	707.04	L89.200 – L89.209	Pressure ulcer of unspecified hip and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.210 – L89.219	Right hip and stage
		L89.220 – L89.229	Left hip and stage
Pressure Ulcer of ***buttock***	707.05	L89.300 – L89.309	Pressure ulcer of unspecified buttock and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.310 – L89.319	Right buttock and stage
		L89.320 – L89.329	Left buttock and stage
		L89.40 – L89.45	Contiguous site of back, buttock and hip
Pressure Ulcer of ***ankle***	707.06	L89.500 – L89.509	Pressure ulcer of unspecified ankle and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.510 – L89.519	Right ankle and stage
		L89.520 – L89.529	Left ankle and stage
Ulcer of ***heel***	707.07	L89.600 – L89.609	Pressure ulcer of unspecified heel and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.610 – L89.619	Right heel and stage
		L89.620 – L89.629	Left heel and stage
Pressure ulcer of ***other site***	707.09	L89.810 – L89.819	Ulcer of head and stage
Pressure Ulcer Stages	707.20 – 707.21	L89.890 – L89.899	Other site and stage
Pressure Ulcer, Unspecified Site	707.00	L89.90 – L89.95	Unspecified site and stage
Pressure Ulcer Stages	707.20 – 707.21		

ICD-10 Conversions for Pressure Ulcer sites/stages.

Pressure Ulcer of Elbow

L89.000—Pressure ulcer of unspecified elbow, unstageable.

L89.001—Pressure ulcer of unspecified elbow, stage 1.

L89.002—Pressure ulcer of unspecified elbow, stage 11.

L89.003—Pressure ulcer of unspecified elbow, stage 111.

L89.004—Pressure ulcer of unspecified elbow, stage 1V.

L89.009—Pressure ulcer of unspecified elbow, unspecified stage.

L89.010—Pressure ulcer of right elbow, unstageable.

L89.011—Pressure ulcer of right elbow, stage 1.

L89.012—Pressure ulcer of right elbow, stage 11.

L89.013—Pressure ulcer of right elbow, stage 111.

L89.014—Pressure ulcer of right elbow, stage 1V.

L89.019—Pressure ulcer of right elbow, unspecified stage.

L89.020—Pressure ulcer of left elbow, unstageable.

L89.021—Pressure ulcer of left elbow, stage 1.

L89.022—Pressure ulcer of left elbow, stage 11.

L89.023—Pressure ulcer of left elbow, stage 111.

L89.024—Pressure ulcer of left elbow, stage 1V.

L89.029—Pressure ulcer of left elbow, unspecified stage.

Pressure ulcer of back:

L89.100—Pressure ulcer of unspecified part of back, unstageable.

L89.101—Pressure ulcer of unspecified part of back, stage 1.

L89.102—Pressure ulcer of unspecified part of back, stage 11.

L89.103—Pressure ulcer of unspecified part of back, stage 111.

L89.104—Pressure ulcer of unspecified part of back, stage 1V.

L89.109—Pressure ulcer of unspecified part of back, unspecified stage.

L89.110—Pressure ulcer of right upper back, unstageable.

L89.111—Pressure ulcer of right upper back, stage 1.

L89.112—Pressure ulcer of right upper back, stage 11.

L89.113—Pressure ulcer of right upper back, stage 111.

L89.114—Pressure ulcer of right upper back, stage 1V.

L89.119—Pressure ulcer of right upper back, unspecified stage.

L89.120—Pressure ulcer of left upper back, unstageable.

L89.121—Pressure ulcer of left upper back, stage 1.

L89.122—Pressure ulcer of left upper back, stage 11.

L89.123—Pressure ulcer of left upper back, stage 111.

L89.124—Pressure ulcer of left upper back, stage 1V.

L89.129—Pressure ulcer of left upper back, unspecified stage.

L89.130—Pressure ulcer of right lower back, unstageable.

L89.131—Pressure ulcer of right lower back, stage 1.

L89.132—Pressure ulcer of right lower back, stage 11.

L89.133—Pressure ulcer of right lower back, stage 111.

L89.134—Pressure ulcer of right lower back, stage 1V.

L89.139—Pressure ulcer of right lower back, unspecified stage.

L89.140—Pressure ulcer of left lower back, unstageable.

L89.141—Pressure ulcer of left lower back, stage 1.

L89.142—Pressure ulcer of left lower back, stage 11.

L89.143—Pressure ulcer of left lower back, stage 111.

L89.144—Pressure ulcer of left lower back, stage 1V.

L89.149—Pressure ulcer of left lower back, unspecified stage.

L89.150—Pressure ulcer of sacral region, unstageable.

L89.151—Pressure ulcer of sacral region, stage 1.

L89.152—Pressure ulcer of sacral region, stage 11.

L89.153—Pressure ulcer of sacral region, stage 111.

L89.154—Pressure ulcer of sacral region, stage 1V.

L89.159—Pressure ulcer of sacral region, unspecified stage.

Pressure Ulcer of hip

L89.200—Pressure ulcer of unspecified hip, unstageable.

L89.201—Pressure ulcer of unspecified hip, stage 1.

L89.202—Pressure ulcer of unspecified hip, stage 11.

L89.203—Pressure ulcer of unspecified hip, stage 111.

L89.204—Pressure ulcer of unspecified hip, stage 1V.

L89.209—Pressure ulcer of unspecified hip, unspecified stage.

L89.210—Pressure ulcer of right hip, unstageable.

L89.211—Pressure ulcer of right hip, stage 1.

L89.212—Pressure ulcer of right hip, stage 11.

L89.213—Pressure ulcer of right hip, stage 111.

L89.214—Pressure ulcer of right hip, stage 1V.

L89.219—Pressure ulcer of right hip, unspecified stage.

L89.220—Pressure ulcer of left hip, unstageable.

L89.221—Pressure ulcer of left hip, stage 1.

L89.222—Pressure ulcer of left hip, stage 11.

L89.223—Pressure ulcer of left hip, stage 111.

L89.224—Pressure ulcer of left hip, stage 1V.

L89.229—Pressure ulcer of left hip, unspecified stage.

Pressure ulcer of contiguous site of back, buttock and hip

L89.40 – Pressure ulcer of contiguous site of back, buttock and hip, unspecified stage

L89.41 – Pressure ulcer of contiguous site of back, buttock and hip, Stage 1

L89.42 – Pressure ulcer of contiguous site of back, buttock and hip, Stage 2

L89.43 – Pressure ulcer of contiguous site of back, buttock and hip, Stage 3

L89.44 – Pressure ulcer of contiguous site of back, buttock and hip, Stage 4

L89.45 – Pressure ulcer of contiguous site of back, buttock and hip, unstageable

Pressure ulcer of ankle

L89.500—Pressure ulcer of unspecified ankle, unstageable.

L89.501—Pressure ulcer of unspecified ankle, stage 1.

L89.502—Pressure ulcer of unspecified ankle, stage 11.

L89.503—Pressure ulcer of unspecified ankle, stage 111.

L89.504—Pressure ulcer of unspecified ankle, stage 1V.

L89.509—Pressure ulcer of unspecified ankle, unspecified stage.

L89.510—Pressure ulcer of right ankle, unstageable.

L89.511—Pressure ulcer of right ankle, stage 1.

L89.512—Pressure ulcer of right ankle, stage 11.

L89.513—Pressure ulcer of right ankle, stage 111.

L89.514—Pressure ulcer of right ankle, stage 1V.

L89.519—Pressure ulcer of right ankle, unspecified stage.

L89.520—Pressure ulcer of left ankle, unstageable.

L89.521—Pressure ulcer of left ankle, stage 1.

L89.522—Pressure ulcer of left ankle, stage 11.

L89.523—Pressure ulcer of left ankle, stage 111.

L89.524—Pressure ulcer of left ankle, stage 1V.

L89.529—Pressure ulcer of left ankle, unspecified stage.

Pressure ulcer of heel.

L89.600—Pressure ulcer of unspecified heel, unstageable.

L89.601—Pressure ulcer of unspecified heel, stage 1.

L89.602—Pressure ulcer of unspecified heel, stage 11.

L89.603—Pressure ulcer of unspecified heel, stage 111.

L89.604—Pressure ulcer of unspecified heel, stage 1V.

L89.609—Pressure ulcer of unspecified heel, unspecified stage.

L89.610—Pressure ulcer of right heel, unstageable.

L89.611—Pressue ulcer of right heel, stage 1.

L89.612—Pressure ulcer of right heel, stage 11.

L89.613—Pressure ulcer of right heel, stage 111.

L89.614—Pressure ulcer of right heel, stage 1V.

L89.619—Pressure ulcer of right heel, unspecified stage.

L89.620—Pressure ulcer of left heel, unstageable.

L89.621—Pressure ulcer of left heel, stage 1.

L89.622—Pressure ulcer of left heel, stage 11.

L89.623—Pressure ulcer of left heel, stage 111.

L89.624—Pressure ulcer of left heel, stage 1V.

L89.629—Pressure ulcer of left heel, unspecified stage

Ulcer of Head

L89.810—Pressure ulcer of head, unstageable.

L89.811—Pressure ulcer of head, stage 1.

L89.812—Pressure ulcer of head, stage 11.

L89.813—Pressure ulcer of head, stage 111.

L89.814—Pressure ulcer of head, stage 1V.

L89.819—Pressure ulcer of head, unspecified stage.

Ulcer of Other Site

L89.890—Pressure ulcer of other site, unstageable.

L89.891—Pressure ulcer of other site, stage 1.

L89.892—Pressure ulcer of other site, stage 11.

L89.893—Pressure ulcer of other site, stage 111.

L89.894—Pressure ulcer of other site, stage 1V.

L89.899—Pressure ulcer of other site, unspecified stage.

Pressure Ulcer of Unspecified Site

L89.90—Pressure ulcer of unspecified site, unstageable.

L89.91—Pressure ulcer of unspecified site, stage 1.

L89.92—Pressure ulcer of unspecified site, stage 11.

L89.93—Pressure ulcer of unspecified site, stage 111.

L89.94—Pressure ulcer of unspecified site, stage 1V.

L89.99—Pressure ulcer of unspecified r site, unspecified stage.